STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121651-001**

Priority Health Insurance Company
Respondent

Issued and entered
this 8th day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 31, 2011, XXXXX, on behalf of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives benefits under a policy underwritten by Priority Health Insurance Company (PHIC). The policy is PHIC's *Preferred Provider Organization Plan PPO Insurance Policy* (the policy). The Commissioner notified PHIC of the external review and requested the information used in making its adverse determination. PHIC furnished the requested information and the Commissioner accepted the request for external review on June 7, 2011.

The issue here can be decided by applying the terms of the policy. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On December 1, 2010, the Petitioner enrolled in PHIC's "HealthbyChoice Incentives" plan. HealthbyChoice is a wellness program that offers two levels of benefits, "choice" and "standard." The "choice" benefit level offers savings to members through lower deductibles and copayments. The requirements of the program are detailed in an addendum to the policy. One

requirement to enter the "choice" program is that the member must have a physician submit to PHIC a medical questionnaire. As explained in the addendum:

> If you do not meet the criteria for the health indicators described on the qualification form, you must undergo appropriate screening tests and agree to follow your Physician's treatment and monitoring plan.

On January 27, 2011, the Petitioner visited a physician as a new patient to undergo the required examination and tests to establish her coverage level. During the office visit, the physician performed an ECG and referred the Petitioner to undergo additional medical tests.

PHIC paid the claims at the "choice" benefit level applying the deductible, copayment and coinsurance specified in the schedule of benefits. The Petitioner appealed the benefit level seeking a waiver of the deductible, coinsurance and copayment because she believes the doctor performed and billed PHIC for unnecessary tests. Petitioner appealed the denial through PHIC's internal grievance process. PHIC upheld its benefit application and issued its final adverse determination to Petitioner on May 10, 2011.

III. ISSUE

Did PHIC correctly process the claim for the Petitioner's medical services received on January 27, 2011?

IV. ANALYSIS

Petitioner's Argument

The Petitioner contends the physician and staff misled her and did not fully explain the reasoning for the additional medical tests and procedures. At the time, she believed the tests to be part of the HealthbyChoice screening process. She now believes some of those tests were unnecessary. The Petitioner also asserts that the physician falsified information in her chart, submitted false information regarding her condition, and needlessly subjected her to radioactive materials. The Petitioner seeks 100% coverage of the expenses she incurred.

Respondent's Argument

In its final adverse determination, PHIC denied the Petitioner's request to have her deductibles and copayments waived:

> **Decision:**
>
> Uphold benefit application – requested coverage will not be provided.
> [Petitioner's] benefits were applied appropriately in accordance with the Insurance Policy and Schedule of Benefits.

> The Appeal Committee understands that [Petitioner] now believes the services to have been unnecessary, however, the services were provided and the medical records support the physician's order, so payment is appropriate.

Commissioner's Review

The Petitioner does not dispute that PHIC paid the claims correctly according to the terms and conditions of the certificate of coverage. The Petitioner's complaint is that the doctor ordered unnecessary tests and falsified information on the medical records related to the Petitioner's January 27 examination.

While the Commissioner is sympathetic to the Petitioner's concerns, the Commissioner is unable to order the remedy sought by the Petitioner. Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether an insurer properly administers benefits under the terms and conditions of the insurance contract. Nothing in the Petitioner's certificate or HealthbyChoice amendment to the certificate requires PHIC to waive the deductibles, copayments, or coinsurance for the medical services actually provided. Therefore, the Commissioner finds that PHIC's payment of claims for medical services that the Petitioner received on January 27, 2011, is consistent with the provisions in her insurance policy and the HealthbyChoice program.

The Petitioner's request for external review involves issues pertaining to the quality of care she received from her physician. The Commissioner has no regulatory authority over physicians. The Petitioner's complaint regarding the conduct of her doctor is beyond the regulatory authority of this agency. The Commissioner notes that PHIC wrote the following in its position paper of June 14, 2011:

> Priority Health appreciates and understands [Petitioner's] concerns regarding unnecessary services and communication issues and has forwarded these concerns to the appropriate departments for further review and investigation.

The Petitioner may also elect file a complaint regarding the physician with the appropriate state regulatory agency:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Professions
Health Investigation Division
P.O. Box 30454
Lansing, MI 48909-9897
(517) 373-9196

V. ORDER

The Commissioner upholds Priority Health Insurance Company's final adverse determination of May 10, 2011. PHIC is not required to provide additional reimbursement for medical services the Petitioner received on January 27, 2011.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner